Special Qualifying Events
&
Enrollment Change Applications

Agency Benefits Coordinator Meeting
Presented by: Tameka Allen
Service Center Manager

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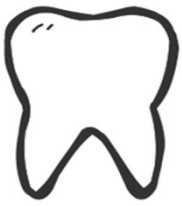
Special Enrollment Provisions

Health Insurance Portability and Accountability Act (HIPAA) is a federal law that allows an employee to enroll in coverage under certain conditions outside of the Annual Open Enrollment period.

Special Enrollment requests can be submitted for:

Health



Dental

Vision

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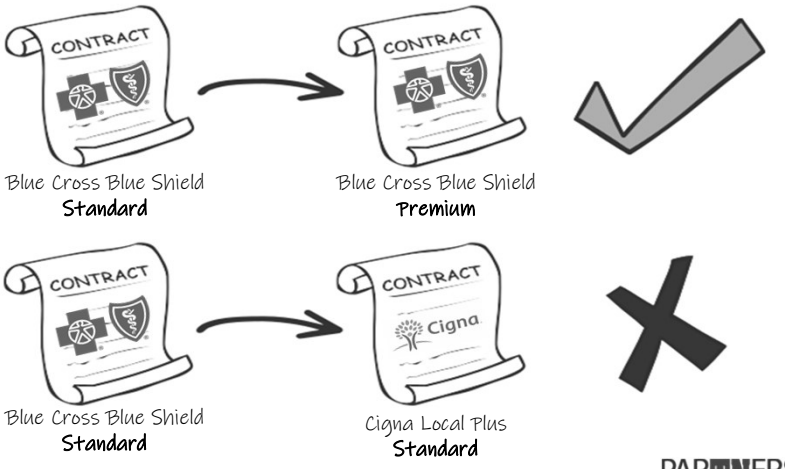
Life Events

Life Events are qualifying events that result in adding dependents that are newly eligible.

- ❑ Marriage
- ❑ Birth/Adoption

If you experience a qualifying life event, you are ONLY allowed to change your coverage level - NOT your vendor.

Note: this does not include non-payment of premium.



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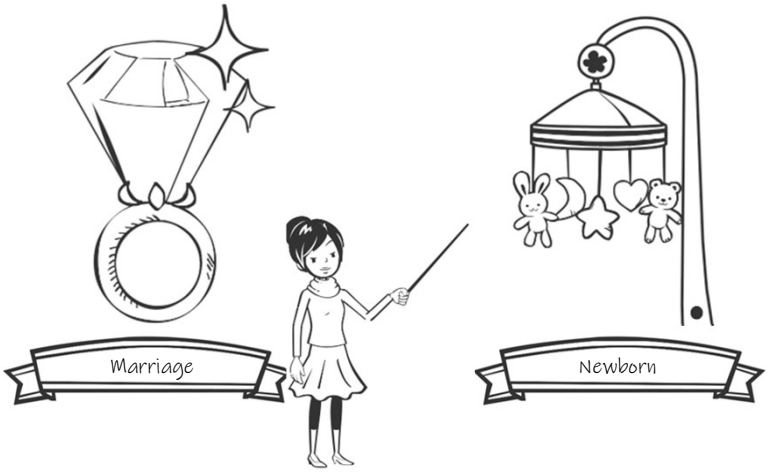
Life Events Continued

We now require a copy of the Social Security card for:



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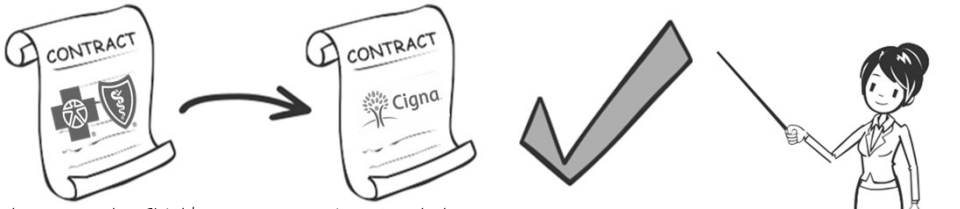
Special Qualifying Events

A special qualifying event (SQE) allows you to enroll in coverage or add previously eligible dependents to your coverage when a loss of eligibility under another plan (group plan or private plan) occurs or when a new dependent is acquired.

- ❑ Divorce
- ❑ Loss of eligibility
- ❑ Loss of a spouse
- ❑ Loss of Tenncare
- ❑ Termination of a spouse's employment
- ❑ Coverage reaches lifetime maximum



Blue Cross Blue Shield
Standard

Cigna Local Plus
Premium

If you experience a Special Qualifying Event, you can transfer to a different carrier or healthcare option, if eligible.

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Special Qualifying Events Video Example #1

- ❑ If you experience an SQE as a result of loss of coverage, only those losing coverage are eligible to enroll.

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Special Qualifying Events Video Example #2

- If you experience an SQE as a result of acquiring a newly eligible dependent, you can add the newly acquired dependent and previously eligible dependents during this time.

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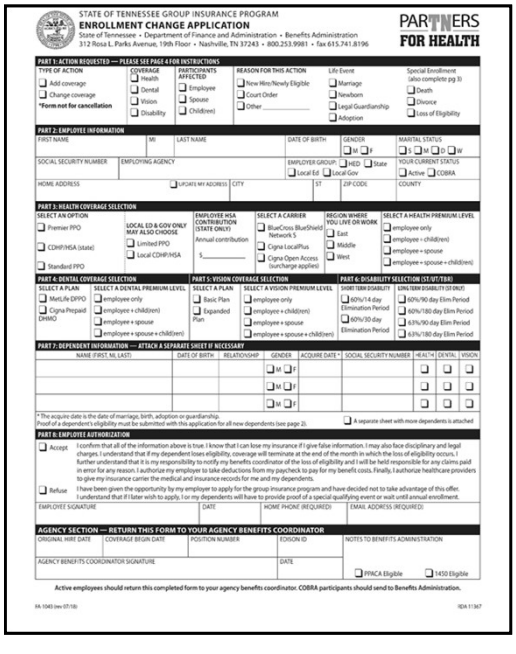

STATE OF TENNESSEE GROUP INSURANCE PROGRAM
ENROLLMENT CHANGE APPLICATION
State of Tennessee • Department of Finance and Administration • Benefits Administration
312 Rosa L. Parks Avenue, 19th Floor • Nashville, TN 37243 • 800.253.9981 • fax 615.741.8196

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PART 1: ACTION REQUESTED — PLEASE SEE PAGE 4 FOR INSTRUCTIONS

TYPE OF ACTION: ☐ Add coverage ☐ Change coverage *Form not for cancellation
COVERAGE: ☐ Health ☐ Dental ☐ Vision ☐ Disability
PARTICIPANTS AFFECTED: ☐ Employee ☐ Spouse ☐ Child(ren)
REASON FOR THIS ACTION: ☐ New Hire/Newly Eligible ☐ Court Order ☐ Other _____
Life Event: ☐ Marriage ☐ Newborn ☐ Legal Guardianship ☐ Adoption
Special Enrollment (also complete pg 3): ☐ Death ☐ Divorce ☐ Loss of Eligibility

PART 2: EMPLOYEE INFORMATION

FIRST NAME | MI | LAST NAME | DATE OF BIRTH | GENDER ☐ M ☐ F | MARITAL STATUS ☐ S ☐ M ☐ D ☐ W
SOCIAL SECURITY NUMBER | EMPLOYING AGENCY | EMPLOYER GROUP ☐ HED ☐ State ☐ Local Ed ☐ Local Gov | YOUR CURRENT STATUS ☐ Active ☐ COBRA
HOME ADDRESS ☐ UPDATE MY ADDRESS | CITY | ST | ZIP CODE | COUNTY

PART 3: HEALTH COVERAGE SELECTION

SELECT AN OPTION: ☐ Premier PPO ☐ CDHP/HSA (state) ☐ Standard PPO
LOCAL ED & GOV ONLY MAY ALSO CHOOSE: ☐ Limited PPO ☐ Local CDHP/HSA
EMPLOYEE HSA CONTRIBUTION (STATE ONLY!) Annual contribution $_____
SELECT A CARRIER: ☐ BlueCross BlueShield Network S ☐ Cigna LocalPlus ☐ Cigna Open Access (surcharge applies)
REGION WHERE YOU LIVE OR WORK: ☐ East ☐ Middle ☐ West
SELECT A HEALTH PREMIUM LEVEL: ☐ employee only ☐ employee + child(ren) ☐ employee + spouse ☐ employee + spouse + child(ren)

PART 4: DENTAL COVERAGE SELECTION

SELECT A PLAN: ☐ MetLife DPPO ☐ Cigna-Prepaid DHMO
SELECT A DENTAL PREMIUM LEVEL: ☐ employee only ☐ employee + child(ren) ☐ employee + spouse ☐ employee + spouse + child(ren)

PART 5: VISION COVERAGE SELECTION

SELECT A PLAN: ☐ Basic Plan ☐ Expanded Plan
SELECT A VISION PREMIUM LEVEL: ☐ employee only ☐ employee + child(ren) ☐ employee + spouse ☐ employee + spouse + child(ren)

PART 6: DISABILITY SELECTION (ST/GT/TBR)

SHORT TERM DISABILITY: ☐ 60%/14 day Elimination Period ☐ 60%/30 day Elimination Period
LONG TERM DISABILITY (ST ONLY): ☐ 60%/90 day Elim Period ☐ 60%/180 day Elim Period ☐ 63%/90 day Elim Period ☐ 63%/180 day Elim Period

PART 7: DEPENDENT INFORMATION — ATTACH A SEPARATE SHEET IF NECESSARY

NAME (FIRST, MI, LAST)	DATE OF BIRTH	RELATIONSHIP	GENDER	ACQUIRE DATE *	SOCIAL SECURITY NUMBER	HEALTH	DENTAL	VISION
			☐ M ☐ F			☐	☐	☐
			☐ M ☐ F			☐	☐	☐
			☐ M ☐ F			☐	☐	☐

* The acquire date is the date of marriage, birth, adoption or guardianship. Proof of a dependent's eligibility must be submitted with this application for all new dependents (see page 2).
☐ A separate sheet with more dependents is attached

PART 8: EMPLOYEE AUTHORIZATION

☐ Accept I confirm that all of the information above is true. I know that I can lose my insurance if I give false information. I may also face disciplinary and legal charges. I understand that if my dependent loses eligibility, coverage will terminate at the end of the month in which the loss of eligibility occurs. I further understand that it is my responsibility to notify my benefits coordinator of the loss of eligibility and I will be held responsible for any claims paid in error for any reason. I authorize my employer to take deductions from my paycheck to pay for my benefit costs. Finally, I authorize healthcare providers to give my insurance carrier the medical and insurance records for me and my dependents.
☐ Refuse I have been given the opportunity by my employer to apply for the group insurance program and have decided not to take advantage of this offer. I understand that if I later wish to apply, I or my dependents will have to provide proof of a special qualifying event or wait until annual enrollment.

EMPLOYEE SIGNATURE | DATE | HOME PHONE (REQUIRED) | EMAIL ADDRESS (REQUIRED)

AGENCY SECTION — RETURN THIS FORM TO YOUR AGENCY BENEFITS COORDINATOR

ORIGINAL HIRE DATE | COVERAGE BEGIN DATE | POSITION NUMBER | VISION ID | NOTES TO BENEFITS ADMINISTRATION
AGENCY BENEFITS COORDINATOR SIGNATURE | DATE
☐ PPACA Eligible ☐ 1450 Eligible

Active employees should return this completed form to your agency benefits coordinator. COBRA participants should send to Benefits Administration.

RA-1043 (rev 07/18) IDA 11367

Enrollment Change Application

This form should be used to **enroll** or **make changes** to coverage.

To find it:
1. Navigate to the TN Partners for Health website.
2. Click on "Agency Benefit Coordinators."
3. Click on "Forms" then "Enrollment Change Application."

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Cancel Request

This form should be used to **terminate** coverage.

To find it:

1. Navigate to the TN Partners for Health website.
2. Click on "Agency Benefit Coordinators."
3. Click on "Forms" then "Insurance Cancel Request Application."

STATE OF TENNESSEE GROUP INSURANCE PROGRAM
INSURANCE CANCEL REQUEST APPLICATION
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NAME	EDISON ID	EMPLOYER GROUP: ☐ HED ☐ STATE ☐ LOCAL ED ☐ LOCAL GOV

PART 1 — PARTICIPANT(S) CANCELING COVERAGE (ATTACH A SEPARATE SHEET IF NECESSARY)

I request to cancel ☐ medical ☐ dental ☐ STD ☐ LTD ☐ vision ☐ FSA/medical ☐ FSA/dep care ☐ FSA/limited ☐ Voluntary AD&D coverage on the participant(s) below due to:

☐ Reason marked in Part 2 below
☐ Prepaid dental; no participating general dentist within a 40-mile radius of my home (skip Parts 2 and 3 below)
☐ Disability; requires 30 days advance written notice (skip Parts 2 and 3 below)
☐ Employee ☐ Spouse ☐ Child(ren) (names):

INSTRUCTIONS

You and/or your dependent(s) may only cancel coverage under the state group insurance program during the annual enrollment period except for one of the following events. (Note: STD and/or LTD may be canceled during the year for any reason.)

1. You and/or your dependent(s) may cancel coverage if you lose eligibility or qualify to cancel for one of the reasons listed below. Only persons who qualify may cancel. You have 60 days from a qualifying event to submit documentation.
2. If enrolled in the prepaid dental option and there is no participating general dentist within a 40-mile radius of your home. The coverage end date will be the last day of the month that this form is received by Benefits Administration.

The purchase of a private policy is not a reason for cancellation of this coverage. Submit all documents to your agency benefits coordinator.

PART 2 — REASON TO REQUEST TO CANCEL

REASON	DOCUMENTATION REQUIRED
☐ Marriage, divorce, legal separation, annulment	Copy of marriage certificate or full divorce decree or legal paperwork signed by judge and proof of other coverage (see #1 above) If divorce, please provide ex-spouse's current address here:
☐ Birth, adoption, placement for adoption	Copy of birth certificate or adoption documents and proof of other coverage (see #1 above)
☐ Death of spouse, dependent	Copy of death certificate
☐ New employment, return from unpaid leave, change from part-time to full-time employment (spouse or dependent)	Letter on employer's company letterhead certifying date of insurance eligibility, date of return from unpaid leave or change in employment status
☐ Entitlement to Medicare, Medicaid, TRICARE	Letter of entitlement from Medicare, Medicaid or TRICARE or copy of new ID card
☐ Court decree or order	Copy of court decree or order signed by judge
☐ Open enrollment	Letter, on company letterhead, certifying date of eligibility for other coverage
☐ A change in your place of residence or workplace out of the national service area (i.e., move out of the U.S.)	Letter stating date of location change with member's new address
☐ Marketplace Enrollment	I attest that I am enrolled or intend to enroll in the Marketplace

PART 3 — REQUESTED COVERAGE END DATE

The coverage end date may either be the last day of the month prior to the eligibility date of other coverage or the last day of the month that the event occurred.	LAST DAY COVERAGE TO BE ACTIVE (MM/DD/YY):

PART 4 — AUTHORIZATION

By signing this application, I attest that I and/or my dependent(s) are eligible to cancel coverage for the reason(s) marked in Part 1 of this form. I also attest that I can cancel disability coverage for any reason. I further attest that the information I am submitting is true and accurate. I understand that by making this request, the participant(s) whose coverage is cancelled may not be eligible for COBRA and that any future request for coverage will be subject to the Plan's eligibility and enrollment rules.

EMPLOYEE SIGNATURE	DATE	PHONE
AGENCY BENEFITS COORDINATOR SIGNATURE	DATE	NOTES

FA-1047 (rev 10/18) RDA 11367

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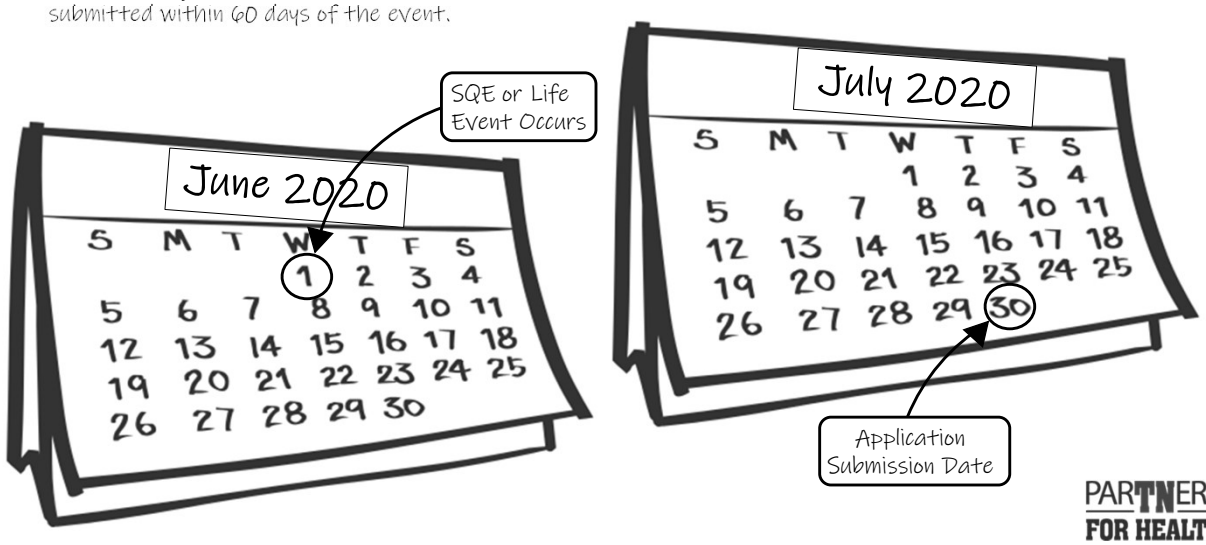
Reminder

When enrolling an employee or dependent due to a SQE or Live Event, the application must be submitted within 60 days of the event.



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Finding Forms

To Find Forms Using the Publications Tab

1. Navigate to the TN Partners for Health website.
2. Click on "Publications."
3. Click on "Forms."

To Find Forms Using the ABC Tab:

1. Navigate to the TN Partners for Health website.
2. Click on "Agency Benefits Coordinator"
3. Click on "Forms"

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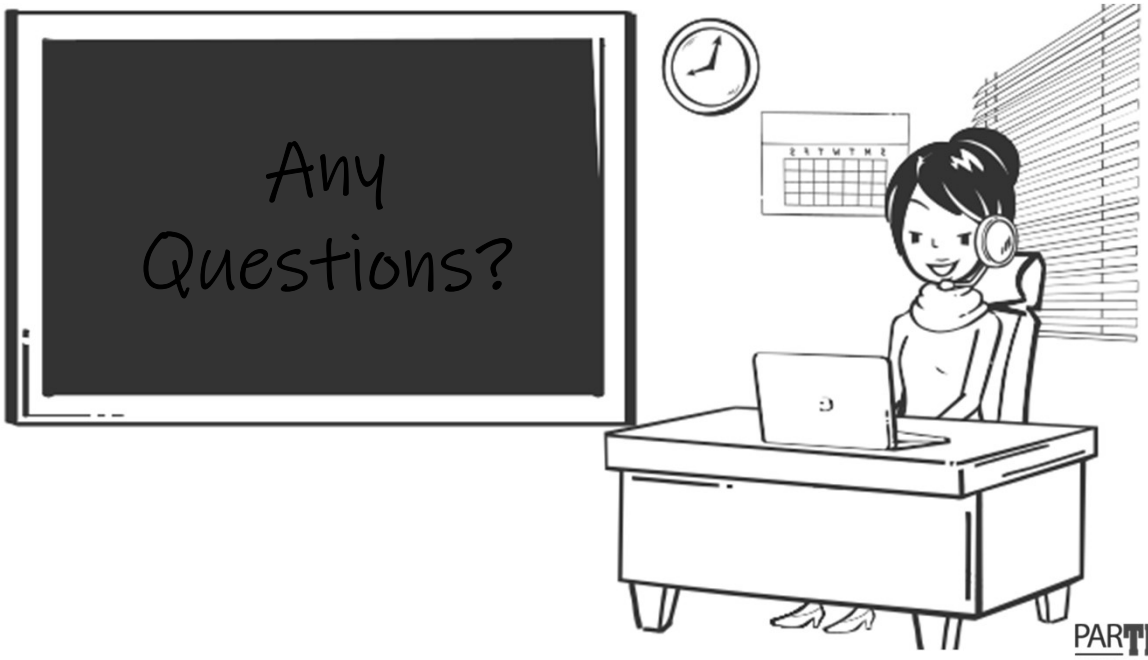

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